



Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

Alternate name _____

Cholera

Phone _____ Email _____

Address type Home Mailing Other Temporary Work

Street address _____

County _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: Investigation start ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ Case complete ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify:* Amer Ind *and/or* AK Native) Asian Black or African American
 Native HI/Pacific Islander (*specify:* Native HI *and/or* Pacific Islander) White Patient declined to respond Unk

Additional race information:

- Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
- Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
- Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
- Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
- Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
- Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
- South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
- Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

- Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
- Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
- Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
- Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
- Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
- Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never

Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed

Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____

Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Signs and Symptoms

Y N Unk

- Any fever**, subjective or measured Temp measured? Yes No Highest measured temp _____ °F
 Diarrhea (3 or more loose stools within a 24 hour period) Onset date ___/___/___ Max # of stools in 24 hrs _____
 Bloody diarrhea
 Abdominal pain or cramps
 Vomiting
 Cellulitis Site of cellulitis _____
 Bullae (blisters) Site of bullae _____
 Myalgia (muscle aches or pain)
 Headache
 Shock
 Any complication _____

Predisposing Conditions

Y N Unk

- Antacid use in 30 days prior to onset Antacid _____
 H2 blocker or ulcer medication (e.g., Tagamet, Zantac, Omeprazole) use in 30 days prior to onset
 Medication _____
 Chemotherapy in 30 days prior to onset Treatment _____ Treatment date ___/___/___
 Chronic heart disease
 Heart failure
 Gastric surgery or gastrectomy in past
 Peptic ulcer
 Liver disease Type _____
 Chronic kidney disease Type _____
 Diabetes mellitus
 Insulin use
 Hematologic disease
 Immunodeficiency
 Immunosuppressive therapy or condition, or disease Specify _____
 Malignancy Type _____
 Alcoholism
 Other underlying medical conditions _____

Vaccination

Y N Unk

Cholera vaccine in past Specify most recent type Oral Parenteral Most recent date received ___/___/___

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Culture Information

Y N Unk

Confirmed at state or federal public health lab

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Disposition Another acute care hospital Facility name _____

Died in hospital

Long term acute care facility Facility name _____

Long term care facility Facility name _____

Non-healthcare (home) Unk Other _____

Y N Unk

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Mechanical ventilation or intubation required

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

Autopsy performed

Death certificate lists disease as a cause of death or a significant contributing condition

Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)

Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 7 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Y N Unk

Foreign travel

If Yes to "Foreign travel",

Had the patient been educated in cholera prevention measures before travel

Which source(s) of information received (check all that apply) Pre-travel clinic Airport departure gate

Newspaper Friends Private physician Health department Travel agency

CDC traveler's hotline Other _____

What was the patient's reason for travel To visit relatives/friends Business Tourism Military Unk

Other _____

Risk and Exposure Information

Y N Unk

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____

Does the case know anyone else with similar symptoms or illness

Known contaminated food product _____

Food Exposure

Sources of food IN home - During exposure timeframe did you (your child) eat foods from:

(1) Grocery stores or supermarkets

(2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc)

(3) Fish or meat specialty shops (butcher shop, etc)

(4) Warehouse stores (Costco, Sam's Club, etc.)

(5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan's, NutriSystem, etc)

(6) Live animal market, custom slaughter facility

(7) Small markets/mini markets (convenience stores, gas stations, etc)

(8) Health food stores or co-ops

(9) Ethnic specialty markets (Mexican, Asian, Indian)

(10) Farmers markets, roadside stands, open-air markets, food purchased directly from a farm

(11) Other _____

Type of Business (enter number next to choices above)	Business name	Address/location

Sources of food outside home - During exposure timeframe did you (your child) eat foods from:

- | | |
|--|--|
| <input type="checkbox"/> (1) Fast casual (Chipolte, Panera, etc) | <input type="checkbox"/> (10) Chinese, Japanese, Vietnamese, other Asian-style |
| <input type="checkbox"/> (2) Fast food (McDonald's, Burger King, Wendy's) | <input type="checkbox"/> (11) All-you-can-eat buffet |
| <input type="checkbox"/> (3) Sandwich shop, deli | <input type="checkbox"/> (12) Breakfast, brunch, diner, or café |
| <input type="checkbox"/> (4) Jamaican, Cuban, or Caribbean | <input type="checkbox"/> (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African |
| <input type="checkbox"/> (5) Ready-to-eat prepared food from grocery or deli | <input type="checkbox"/> (14) Any takeout from a restaurant |
| <input type="checkbox"/> (6) An event where food was served (catered event, festival, church, or community meal) | <input type="checkbox"/> (15) Healthy restaurant (vegetarian, vegan, salad-based) |
| <input type="checkbox"/> (7) Mexican, Salvadorian, other Hispanic/Latino-style | <input type="checkbox"/> (16) Salad bar at a grocery store or restaurant |
| <input type="checkbox"/> (8) Food trucks, food stalls/stands | <input type="checkbox"/> (17) Other _____ |
| <input type="checkbox"/> (9) School, hospital, senior center, or other institutional setting | |

Type of Business (enter number next to choices above)	Restaurant/venue name	Date	Time of meal (Breakfast, Brunch, Lunch, Happy Hour, Dinner, Other)	Food ordered/eaten	Address/location
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		

Y M N Unk

Any food sampled (grocery, warehouse stores, food court, etc.) _____

Y N Unk

Consumed shellfish or seafood during the 7 days before onset of illness

Type	Eaten Y N U	Eaten Raw Y N U	Multiple Dates Y N U	Last date consumed	Type	Eaten Y N U	Eaten Raw Y N U	Multiple Dates Y N U	Last date consumed
Clams	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Mussels	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___
Crabs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Oysters	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___
Crawfish	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Scallops	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___

Fish	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Shrimp	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___
Lobster	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Other shellfish (specify)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___

Please fill in below if investigating specific seafood

Type of seafood being investigated (from list above) _____

Date of consumption of the seafood being investigated ___/___/___ Amount consumed _____

How prepared Fully cooked Undercooked Raw Unknown

Additional relevant information on product preparation (e.g., specific variety of seafood consumed and plating)

Y N Unk

Any dining partners consume the same seafood

Any become ill Describe _____

How was the seafood obtained Harvested by the patient or a friend of the patient Oyster bar or restaurant

Seafood market Truck or roadside vendor Food store Other

Name of location where seafood was obtained _____ Phone # _____

Address _____ Date received ___/___/___

Y N Unk

Was this seafood imported from another country Exporting country _____

Was this business inspected as part of this investigation

Was there evidence of improper handling or storage (check all that apply)

Holding temperature violation Cross-contamination Co-mingling of live and dead shellfish

Improper storage Other _____

How were the shellfish distributed to the business Shellstock (sold in shell) Shucked Unk Other _____

Y N Unk

Are shipping tags available from the suspected lot *If Yes, attach tags to the record*

CDC surveillance form completed

Exposure and Transmission Summary

Y N Unk

Epi-linked to a confirmed case

Likely geographic region of exposure In Washington – county _____ Other state _____

Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Foodborne Waterborne Person to person Sexual Unk

Other _____

Describe _____

Suspected exposure setting Home Work College Military Place of worship International travel

Out of state travel Transit Social event Large public gathering Restaurant Hotel/motel/hostel

Other _____

Describe _____

Exposure summary

Suspected transmission type Foodborne Waterborne Person to person Sexual Unk

Other _____

Describe _____

Suspected transmission setting Home Work College Military Place of worship International travel

Out of state travel Transit Social event Large public gathering Restaurant Hotel/motel/hostel

Other _____

Describe _____

Public Health Issues

Y N Unk

- Does patient have contact with a day care
- Non-occupational food handling (e.g., potlucks, receptions) during contagious period
- Employed as a food handler
- Employed in childcare or preschool

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

- Test symptomatic contacts
- Patient education provided
- Letter sent Date ___/___/___ Batch date ___/___/___
- Any other public health action _____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Daycare School Airport Hotel/Motel/Hostel Transit Healthcare Home Work College
- Military Correctional facility Place of worship International travel Out of state travel LTCF
- Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out contact tracing form Question Package

TREATMENT

Y N Unk

- Did patient receive prophylaxis/treatment
- Specify medication _____ Antibiotic Other
- Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___
- Prescribing provider _____

NOTES

LAB RESULTSLab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.